BACKGROUND PAPER FOR HEARING

MEDICAL BOARD OF CALIFORNIA

IDENTIFIED ISSUES, QUESTIONS FOR THE BOARD AND BACKGROUND CONCERNING THE ISSUES

PRIOR SUNSET REVIEW: The Medical Board of California (Board) was last reviewed by the Joint Legislative Sunset Review Committee (JLSRC) four years ago (1997-98). The JLSRC and the Department of Consumer Affairs (DCA) identified a number of issues and problem areas concerning this Board and directed the Board to implement a number of recommendations and changes. Some of these included: (1) to take a number of specified steps to improve the Board's enforcement program; (2) reexamination of the current process which authorizes the Board to issue interim suspension orders; (3) research of an appropriate approach to privatizing the Board's diversion program; (4) providing justification for a fee increase and finding ways to reduce costs; (5) elimination of the Board's oral examination for out-of-state and foreign graduates; (6) for the Board to stay current on the changing and emerging treatment modalities in medicine, including those associated with "alternative medicine," and for the Board to make recommendations to the Legislature on ways to assure the appropriate oversight of those involved in non-traditional, experimental, or alternative medical modalities. The JLSRC also found that there was sufficient evidence to recommend the continued licensure of physicians and surgeons by the Board, but that any new or additional license classifications such as naturopaths, homeopaths, perfusionists, etc., be subject to the mandates of Section 9148 et seq. of the Government Code (This is a "sunrise process" similar to the current sunset review process of the JLSRC, but is conducted by the standing committees of the Legislature.)

In September, 2001 the Board submitted its required sunset report to the JLSRC. In this report, information of which is provided in Members' binders, the Board described actions it has taken since the Board's prior review. The Board addressed several issues presented by the JLSRC and Legislature over the past four years and also implemented some of the following changes pursuant to legislation and on its own initiative since its last review. This included:

- Attempts to increase revenue for enforcement purposes through a fee increase.

- Legislation and regulations to improve the Enforcement Program, including increased penalties for non-reporting of disciplinary actions within health facilities and shortening the period for investigation and prosecution of disciplinary cases. Also efforts to retain trained investigators and deal with the high number of vacancies within southern California district offices.

- Recruiting medical expert reviewers to ensure that medical experts are available to address such areas as the treatment of pain management and use of complementary and alternative medicine.

- An independent review of the Licensing Program to deal with delays in the licensing process.

- Implementing and adopting regulations regarding approval of specialty boards and advertising of board specialties.

- Forming a Plastic and Cosmetic Surgery Committee in 1996, to deal with implementation of laws regarding accreditation of outpatient surgery facilities, reporting requirements of these facilities, misleading advertising associated with plastic and cosmetic surgery, unlicensed activity, and more recently to adopt standards regarding liposuction.

- Forming a Diversion Task Force to review the Diversion Program and make changes to the administration of the program.

- Forming an Alternative Medicine Committee in 2000, to determine what guidelines may be necessary for practitioners using non-conventional methods and to develop investigative and disciplinary guidelines for cases involving alternative medicine.

- Expansion of the Board's web site along with increased information provided to the public.

- Forming a Telemedicine Committee to address issues involving both teleconsulting (physcian-to-physician) and telepractice (physician-to-patient) practice over the Internet.

- Forming a Teleprescribing Committee to address issues involving prescribing and dispensing of drugs over the Internet, and in 2001 dedicating an investigator position to Internet crimes by creating an Internet Crime Specialist.

- Recent participation in efforts to address the healthcare access of populations within underserved areas and those receiving substandard care because of language or cultural barriers.

Beginning on the next page are a number of unresolved issues pertaining to this Board, or areas of concern for the JLSRC, along with background information concerning the particular issue. There are also questions that staff has asked concerning the particular issue. The Board was provided with these issues and questions and is prepared to address each one if necessary.

CURRENT SUNSET REVIEW ISSUES

BUDGETARY ISSUES

ISSUE #1: When will a fee increase for the Board be necessary?

Question #1 for the Board: *Please explain what programs and services will experience larger expenditures in the future. Does the Board anticipate requesting a fee increase sometime in the near future to deal with an overall decrease in its revenues versus increased expenditures by fiscal year 2004/05? Are there any cost saving measures the Board could initiate such as in information technology services.*

Background: Since its last review, the Medical Board has experienced a significant rise in costs without an equal rise in revenue. Additional costs have been incurred in both the investigation and prosecution of disciplinary cases. There is also a legal case pending before the California Supreme Court regarding the ability of boards to collect some of these costs in the future (cost recovery). The Board also indicates that it will face a number of large expenditures in the future for several programs and services, particularly those related to technology. It is anticipated that the Medical Board will have less than one month in reserve by fiscal year 2004/05. It is generally recommended that boards have at least three to six months reserve for exigent circumstances.

LICENSURE ISSUES

ISSUE #2: What is the Board doing to deal with substantial delays in the Licensing Program incurred during the year 2001?

Question #2 for the Board: *Why does the Board suspect these delays were encountered? What does the Board anticipate doing to assure timely licensing of new physician applicants in the future?*

Background: In 2001, substantial delays were encountered in the licensing of new physicians. The Board has recognized that there is a growing application workload that may result in further delays in the future if adjustments and improvements are not made to address it. To obtain an objective assessment of the Board's Licensing operations, and to solicit expert recommendations for remedies of the problems being experience, in 2001, the Board contracted with CPS Human Resource Services. In June, after evaluating the processes of the program, as well as interviewing staff and managers, CPS made a number of observations and recommendations.

ISSUE #3: Should postgraduate training be increased by one year?

Question #3 for the Board: *When does the Board anticipate the study to be completed and has the Board given any consideration to a "limited license" as is required for podiatrists involved in postgraduate training?*

Background: One year of postgraduate training in an approved postgraduate training program is required for U.S. graduates and two years for international graduates. Nationally, there is some

variability with many states requiring two or three years. The Federation of State Medical Boards has adopted a position that full licensure should be delayed until a third year of postgraduate training and urges all states to adopt this standard. During the last review, the JLSRC recommended that the Board not increase postgraduate study to two years because of lack of justification. The Board is currently involved in a study to determine if an additional year of postgraduate training should be required before licensure. Because of concerns regarding the practice of podiatric medicine by those participating in postgraduate training, the Board of Podiatric Medicine requires a "limited license" to provide appropriate oversight until postgraduate training is completed. Might this "limited license" requirement for physicians allow the Medical Board appropriate oversight of postgraduate training and at least allow certain licensed medical practice to occur, rather awaiting full licensure for two to three years?

ISSUE #4: Should the Board be given authority to compel psychiatric examinations for applicants if there is an indication of mental illness?

Question #4 for the Board: *How would the Board determine that an examination may be necessary and what procedures would it follow to insure that examinations are only required where warranted?*

Background: The Board has indicated it receives licensing applications from physicians or students who have demonstrated behavior that may indicated mental illness that would prevent them from practicing medicine safely. They can request the applicant to submit voluntarily to a psychiatric examination but that it does not have authority to compel an exam. In rare instances, the Board indicates that it would be desirable to have authority to compel this type of examination.

ISSUE #5: Have there been problems with implementing the Licensed Midwives Practicing Act and in defining and implementing the requirement for physician supervision?

Question #5 for the Board: *When does the Board anticipate regulations to be adopted to implement SB 1479? Does the fact that there are no accredited midwifery education programs in California prevent those within the state from qualifying to become licensed midwives or attempting to enter into the profession? What is the Board's official policy on physician supervision? Have licensed midwives been provided clear notice of this policy? Has the Board reviewed the statutory interpretation of physician supervision set out in the Osborn decision? Is the Board's policy consistent with this decision? Are the statutory interpretations adopted by the Board through this decision being adhered to in subsequent interpretations? What is the basis on which the Board continues to pursue disciplinary actions against licensed midwives for lack of physician supervision? Would a different definition of supervision from that defined in the Osborn decision or regulations allow the practice of licensed midwifery in California?*

Background: SB 1479 (Figueroa, Chapter 303, Statutes 2000) increased the requirements for informed consent that licensed midwives must provided to clients and allows midwives to register the birth. The Board scheduled a committee meeting in September 2001 to review these requirements and to discuss possibly regulatory language with interested parties. The Board also indicated that there are currently no accredited midwifery educational programs functioning in California and that all individuals for licensure have done so via reciprocity or through an experiential program offering credit for previous midwifery training and experience called the "challenge mechanism."

California licensed midwives (LMs) are in a difficult position with regards to the enforcement of the physician supervision provision of the Licensed Midwifery Practicing Act (LMPA). On one hand, the LMPA requires all LMs to have physician supervision. This is not defined in statute, rather, the statute only says that supervision "does not require the physical presence of the supervising physician." On the other, due to liability concerns, no physician will provide supervision or work with LMs who provide community-based birth services. Thus, any time a California LM attends a home delivery, which is exactly what they are licensed to do by the Board, even if the LM has been working with a physician, he/she is without "physician supervision" as interpreted by the Medical Board. Consequently, the LM is in violation of her scope of practice, and may be disciplined by the Board regardless of the outcome of the birth. Although most LMs have an informal consultative relationship with a physician, this had not been considered as "supervision" due to lack of a formal relationship.

However, in August 1999, licensed midwives thought that the problem was resolved when Administrative Law Judge Jaime Roman made a ruling in an administrative law decision which defined physician supervision. Judge Roman ruled that the midwife, Allison Osborn, did nothing wrong in delivering a child without formal physician supervision, because, as he put it, "In an effort to promote the efficacy of the Act, this tribunal concludes, at this time, that a licensed midwife who possesses a relationship with a California physician or surgeon as referenced herein has feasibly and reasonably satisfied the ambit of the Act." The relationship referenced by Judge Roman is one where LMs, "with the cooperation of physicians sympathetic to their plight and who seek to expand the options available to patients, developed a relationship that involves collegial referral and assistance, collaboration, and emergent assistance without direct or accountable physician and surgeon supervision of licensed midwives." This interpretation of physician supervision is consistent with the spirit of the law and the practical application of enforcement standards. It upholds the statute while allowing the licensed midwives to practice. Subsequently, the Medical Board of California accepted Judge Roman's proposed decision and dismissed the case against Allison Osborn. In doing so, California licensed midwives believed appropriately that the Board was thus accepting the decision's statutory interpretation of physician supervision. Beyond the Osborn decision, and in the absence of regulatory interpretation of physician supervision, no workable definition of supervision exists to orient licensees toward acting within their scope of practice.

The JLSRC has heard from reliable sources that the Board is pursuing disciplinary actions against licensed midwives for practicing without physician supervision. This is troubling to the JLSRC for two reasons. First, by dismissing the case against Allison Osborn, the Board adopted the proposed decision and thus accepted the statutory interpretation of physician supervision offered by Judge Roman. Unless the Board has taken action since accepting the decision to reverse or disagree with all or sections of this decision, one reasons that the acceptance of this decision would demonstrate the Board's agreement with the principles and interpretation of the decision. If this were not the case, the Board should have disagreed with the proposed decision when presented with it or taken formal steps to overrule it at a later point. To accept the decision, then proceed as if it had never occurred, is terribly confusing to the licensees. Second, granted that information is lacking about current cases, if the Board is continuing to proceed with disciplinary actions against LMs for lack of supervision, with no regard to the statutory interpretation brought forth by Judge Roman, then the Board is acting capriciously and unequally toward licensees who are merely looking for direction on how to practice their licensed profession without being in violation. Though administrative law cases are not necessarily "precedent setting", it is disturbing that the Board would accept a statutory interpretation in one case, then apply a different interpretation without basis or logical explanation for the difference in a subsequent and similar case.

ISSUE #6: Is it appropriate for the Board to continue regulating other health care professionals who are not physicians and surgeons?

Question #6 for the Board: *Does the Board perceive any problems with removing the Board's authority over affiliated hearing art professionals and transferring that authority to a new board or bureau?*

Background: Over the years, the Legislature has assigned to the Medical Board responsibility for licensing, registering or regulating various affiliated healing arts professionals. Currently, those licensed or registered by the Board are Licensed Midwives, Registered Dispensing Opticians (including Spectacle Lens and Contact Lens Dispensers), and Research Psychoanalysts. The Board also has responsibility for regulating Medical Assistants. There are also proposals being considered for licensing of health care professionals who are not currently licensed by California, and for the Board to assume responsibility for regulating those professionals as well. With limited resources of the Board currently, and possible budgetary problems in the future, as well as the problems associated with shifting authority of the Board into areas not involving the regulation of physicians and surgeons, it may be time to consider a bureau or board for affiliated healing art professionals and to transfer the authority of the Board over current other health care professionals to this new bureau or board.

ISSUE #7: What is the Board's involvement in issues related to physician shortages and providing health care to underserved areas?

Question #7 for the Board: *What has been the extent of the Board's involvement in the issues related to physician shortages and providing care to the underserved areas? What are the Board's suggestions or recommendations regarding both of these issues? Do discussions involve changing licensing requirements, providing for temporary licensure, changing reciprocity requirements, etc.?*

Background: Recently, there were discussions by the Center for the Health Professions and the California Medical Association regarding physician shortages throughout the State. The Board has also been involved in discussions regarding healthcare access of populations within California who traditionally experience either no care, or substandard medical care because of language or cultural barriers.

ISSUE #8: Could licensing and fee requirements be changes so physicians in retired or inactive status, or whose license has lapsed, could be utilized for state or federal emergencies?

Question #8 for the Board: *Explain how the Board has been approached about this issue. Would it be possible to streamline the licensing process for physicians who are not actively engaged in the practice of medicine so that they could serve in some capacity in a time of state or national crisis? How many physicians currently have lapsed, retired or inactive licenses?*

Background: Both the JLSRC and the Board have been approached about attempting to streamline the licensing process and waiving particular licensing fees and continuing education requirements for licensees who have allowed their license to lapse, or have a retired or inactive license, so as to allow them the opportunity to serve in times of a state or national crisis, or where there is currently a severe need for physicians.

ISSUE #9: Why has the law requiring approval of specialty boards been problematic?

Question #9 for the Board: *What have been the problems associated with implementing this law and are there still outstanding issues or problems to deal with in the future?*

Background: In 1990, SB 2036 (McCorquodale), a bill sponsored by the California Society of Plastic Surgeons, among others, sought to prohibit physicians from advertising board certification who were certified by "weekend boards," or other entities that were not genuine certifying agents. At the time, this bill was referred to as the "bogus board" bill. The law (B& P Code 651(h)(5)(A)&(B)) prohibits physicians from advertising that they are "board certified" or "board eligible" unless they are certified by an American Board of Medical Specialties (ABMS) specialty board, or a board approved by the Medical Board of California. This law, as indicated by the Board, has been problematic and the subject of four lawsuits since its passage. Despite these problems, however, the Board has attempted to administer this law in a manner that makes it meaningful and helpful to consumers. Since the regulations were adopted, the Division of Licensing of the Board has reviewed a number of specialty board applications. Specialty boards that have been approved by the Medical Board are:

1. The American Board of Facial Plastic & Reconstructive Surgery
2. The American Board of Pain Medicine
3. The American Board of Sleep Medicine

Specialty boards that applied, but were not approved are:

1. The American Academy of Pain Management
2. The American Board of Cosmetic Surgery

Specialty boards approved by the Board mean that they meet training and standards for certification that are deemed to be "equivalent" to an ABMS board, as defined by regulations. Disapproval means that the specialty board failed to demonstrate that they meet the regulatory requirements.

PROFESSIONAL AND ETHICAL PRACTICE ISSUES

ISSUE #10: What studies are being conducted by the Board to improve the quality and safety of healthcare provided to consumers?

Question #10 for the Board: *Please explain the studies which the Board is conducting and how they may improve the overall quality and safety of healthcare received by patients?*

Background: The Board has indicated that they are doing several studies to enhance the quality and safety of healthcare and to reduce medical errors and occurrence of patient harm.

ISSUE #11: Are there problems with the implementation of SB 16?

Question #11 for the Board: *Will the Board still be able to conduct the study on the peer review process and pursue a program to provide practitioner remediation?*

Background: SB 16 (Figueroa, Chapter 614, Statutes 2001) was signed by the Governor this year and was a measure intended to deal with problems associated with the peer review reporting process. However, the Governor indicated in his signing of the bill that the Board must conduct all studies and new programs pertaining to this measure within existing resources. SB 16 required a study to be

conducted of the peer review process and for the Board to pursue a program for identifying practitioners in need of remedial training and direct them to effective providers of such training and education. It is unknown whether the Board will be able to conduct the study and proceed with implementation of a remedial training program for physicians.

CONTINUING COMPETENCY ISSUES

ISSUE #12: Are changes needed to the Board's continuing medical education (CME) program?

Question #12 for the Board: *What are the parameters and considerations being made within the study and when does the Board anticipate the study to be completed?*

Background: The requirement for CME is a long-standing feature of physician licensing. To ensure that physicians keep pace with the changing and complex field of medicine, the Board requires completion of an average of 25 hour of approved CME each year and a minimum of 100 hours every four years. A random audit of the licensee population is conducted each year to verify compliance with the CME requirement; those found not to be in compliance are subject to citations and fines. The Board indicated that it has made no changes in its CME program since its last sunset review, but indicates that is currently engaged in a study designed to determine if there are ways to enhance continued knowledge and competency of physicians.

ENFORCEMENT ISSUES

ISSUE #13: What improvements has the Board made to its enforcement program since its last sunset review four years ago?

Question #13 for the Board: *What improvements has the Board made to its Enforcement Program and what other changes are anticipated to improve the program? How have these changes improved performance of the Enforcement Program in responding to consumer complaints?*

Background: During the prior sunset review, the JLSRC recommended that the Board take several steps to improve its enforcement program. They included: (1) Place Deputy Attorney General's in all of its 12 district offices to speed up and improve its enforcement efforts. (2) Alter legal requirements or procedures, and/or increase penalties for non-compliance with Board subpoenas to obtain medical records and for failure to comply with other reporting requirements in the law, particularly relating to peer review actions. (3) Improve the Board's ability to effectively document data relevant to the Board's specific enforcement functions. (4) Take steps to eliminate the endemic vacancies in the Board's investigator positions, particularly in the Los Angeles area.

ISSUE #14: Are there still problems with receiving information from those who are required to report to the Board regarding malpractice settlements, judgments, felony convictions, etc.

Question #14 for the Board: *Is the Board still experiencing significant difficulties in obtaining information from the various reporting entities, and if so, what changes or improvements can be made to the existing reporting requirements?*

Background: In the past, the Board has experienced significant difficulties in obtaining information which is required to be reported to the Board including malpractice settlements, judgments, felony convictions, findings from a pathologist that a death is a result of physician's gross negligence or incompetence, and reports of disciplinary actions taken against a physician or surgeon by a health care facility. For the past four years, the Board has received on average about 1000 reports from insurers or state or local agencies regarding malpractice settlements over $30,000 or arbitration settlements, and about 200 to 400 reports from attorneys or employers. It has only received on average about 25 reports of malpractice judgments from county clerks. It receives on average about 30 reports from district attorneys regarding felony convictions. It received on average about 30 reports from coroners indicating a death of a patient as a result of a physicians gross negligence or incompetence. It received on average about 110 reports regarding disciplinary actions taken against a physician by a health facility. The extent of reporting seems relatively low over the past four years for all of these reporting entities.

ISSUE #15: Why are there fewer disciplinary actions being taken by the Board?

Question #15 for the Board: *Are there reasons why disciplinary actions taken by the Board against physicians may be on the decline?*

Background: For the past eight years complaints have risen significantly, from approximately 8000 in 1993/94 to almost 11,000 in 2000/01. Yet the number of disciplinary actions taken by the Board are beginning to decline, from a high of 383 in 1997/98, to 288 in 2000/01. Is this cause for concern?

ISSUE #16: The disciplinary process of the Board is still rather lengthy, taking on average of about two and a half years from the time a complaint is filed to final disciplinary action?

Question #16 for the Board: *What efforts has the Board made to streamline the process and are there other improvements that can be made to decrease the amount of time it takes to investigate and prosecute disciplinary cases?*

Background: It is still taking on average about two and a half years from the date a complaint is filed till final disciplinary action is taken against the physician. However, the Board has made significant reductions in the amount of time it use to take to process and investigate a complaint, as well as in the time it takes to file an accusation against a physician. Over the past eight years this time frame has been reduced from almost three and half years to the current two and a half years.

ISSUE #17: There is still a high dissatisfaction with the Board by those who file complaints, but the Board has made significant improvements in communicating with complainants.

Question #17 for the Board: *Please explain the effort the Board has made to improve communication with complainants, why dissatisfaction with the outcome of the consumers complaint is still high, and what other improvements the Board intends to make to provide better overall service to the complainant.*

Background: As indicated by the Board, as part of its 1997 sunset review, a satisfaction survey was conducted by the Board as requested by the JLSRC. The results were alarmingly poor, showing that most of those filing complaints were highly dissatisfied with the outcome of their case (about 75%) and the overall service provided by the Board (about 60%). Since that time the Board has made some strides in attempting to maintain better communication with complainants and the recent survey seems to reflect that effort. About 80% of complainants are satisfied with the information and assistance they receive from staff of the Board, compared to about 53% in 1997, and about 53% are satisfied with the advice they receive on the handling of their complaint, compared to about 31% in 1997. However, there is still a high dissatisfaction with the outcome of their particular case, but improvements have been made. About 35% in 2000 were satisfied with overall service provided by the Board, as compared to 24% in 1997.

ISSUE #18: Currently a physician could be found to have sexually abused a patient and still be allowed to continue to practice.

Question #18 for the Board: *Should the license of a physician be automatically revoked if they are found to have engaged in any sexual exploitation of a patient as defined in Section 729 of the Business and Professions code? Please provide information on the number of cases in which a physician has been found to have violated Section 729 over the past four years and the disposition of their case. What disciplinary action was taken?*

Background: Psychologists, Respiratory Care Practitioners and Clinical Social Workers license is subject to automatic revocation if there is a finding by an administrative law judge that any of these practitioners have engaged in any sexual contact with a patient, or committed an act of sexual abuse or sexual exploitation of a patient as defined in Section 729 of the Business and Professions Code, or been convicted of a sex offense as generally defined. A physician is not subject to this provision and could be allowed to continue their practice even though they have been found to be in violation of Section 729 or other sexual offense.

ISSUE #19: What action is the Board taking against unlicensed practice, especially in clinic settings, and is there a need for statutory changes dealing with the unlicensed practice of medicine and for impersonating a physician?

Question #19 for the Board: Please explain actions the Board is taking to curtail unlicensed practice, especially in health clinic settings and the need for the recommended statutory changes.

Background: The Board is currently involved in efforts to prevent unlicensed practice in health clinics primarily serving depressed socioeconomic populations. The Board is also recommending changes to two statutes involving the unlicensed practice of medicine and adopting a statute to deal with impersonating a physician.

ISSUE #20: Is there a need to increase the fine authority of the Board for cases involving financial fraud?

Question #20 for the Board: *Please indicate what particular activities or violations of the Medical Practices Act would warrant fines, and at what level should the fines be set.*

Background: The Board currently has authority to only cite and fine physicians for relatively minor offenses that do not rise to the level of formal disciplinary action. The Board is recommending that it also have authority to fine in instances where the disciplinary action involves financial fraud such as billing or insurance fraud, embezzlement and extortion.

ISSUE #21: What action is the Board taking to deal with the issue of pain management and appropriate prescribing?

Question #21 for the Board: *What action has the Board taken to assure implementation of recent legislation regarding pain management? Are there other laws or programs the Board believes necessary to deal with this issue?*

Background: Since the last sunset review, there have been a number of laws passed that relate to pain mangement. SB 402 (Green, Chapter 839, Statutes 1997) established the "Pain Patient's Bill of Rights." Physicians may refuse to prescribe opioid medication for patients who request the treatment for severe chronic intractable pain, however they must inform the patient that other physicians specialize in the treatment of such pain with methods that include the use of opiates. AB 2305 (Runner, Chapter 984, Statutes 1998) provides that physicians who are in compliance with the California Intractable Pain Act will not be subject to disciplinary action, and that medical expert reviewers retained for an investigation of complaints relative to prescribing for pain must be specialists in pain management. SB 1140 (Chapter 791, Statutes 1998) requires the Medical Board to consider including a course on pain management in CME requirements and to periodically develop and disseminate information and educational material regarding pain management techniques and procedures to physicians and general acute care facilities. AB 791 (Thomson, Chapter 403, Statutes 1999) added pain management and end-of-life care to the curriculum requirements for students entering medical school on or after June 1, 2000.

According to the Board, pain management is a topic of much debate and that there is general agreement from those within and outside of the profession that patients suffering from pain are often undertreated by physicians for various reasons, including fear of disciplinary action for excessive prescribing of opiates. Finding the balance between encouraging adequate prescribing while discouraging excessive and dangerous prescribing may have sent mixed messages to the profession. The Board indicates that it is committed to finding an appropriate balance and educating physicians so that those suffering from pain receive appropriate and adequate relief, and that it is working to expand the Board's experts to include specialists dedicated to pain management, and is committed to working with the Legislature in drafting laws and programs to bring about positive change.

ISSUE #22: There has been a substantial increase in the use of psychiatric drugs for children, especially those diagnosed as having Attention Deficit/Hyperactivity Disorder (ADHD)?

Question #22 for the Board: *Does the Board have some concerns regarding increasing use of psychiatric drugs for children and what actions does the Board believe are necessary to assure that the overprescribing of psychiatric drugs does not occur?*

Background: Over the past five years there has been a substantial increase in the use of psychiatric drugs for school age children who are diagnosed a having ADHD. It is estimated that between 8 to 10 million children are now being medicated with Schedule II drugs, including such stimulants as Adderall, Concerta and Ritalin. Last year, physicians wrote about 20.6 million prescriptions for these types of stimulants, an increase of almost 37% since 1997. The sale of these drugs has also grown into almost a 1 billion-dollar industry in just the past five years. The pharmaceutical industry was accused this year by Drug Enforcement Agency (DEA) of using questionable practices in their advertisements of these drugs and in marketing of these drugs to physicians. Cease and desist orders were sent out by DEA to particular pharmaceutical companies for their marketing gimmickry. The Senate Business and Professions Committee will be holding a hearing on this issue on January 8, 2002, because of concerns raised by certain groups and organizations representing parents and children and health care practitioners, and numerous individuals including physicians and psychiatrists.

ISSUE #23: What has the Board done to implement recent legislation regarding plastic and cosmetic surgery and to deal with related cosmetic procedures that may be unlawful?

Question #23 for the Board: *What action is the Board taking to implement SB 836 and SB 450, and when will the Board adopt extraction and postoperative care standards for liposuction as required by SB 450? Also, what action has the Board taken regarding the use of lasers for hair removal or other type of cosmetic procedures that would be considered the practice of medicine?*

Background: There have been a number of bills to deal with problems regarding plastic and cosmetic surgery. SB 836 (Figueroa, Chapter 856, Statutes 1999) made the advertising law (B&P Code 651) more specific in order to identify and take action for misleading, and thus illegal marketing practices in the advertising of plastic and cosmetic surgery treatments. SB 450 (Speier, Chapter 631, Statutes 1999) also addressed the issue of advertising for plastic and cosmetic surgery and required the Board to adopt extraction and postoperative care standards for liposuction. There have also been instances in which the Board needed to address other related cosmetic procedures that are being used by untrained or unlicensed practitioners and involve the practice of medicine.

ISSUE #24: Why has the Outpatient Surgery Accreditation Law been difficult to implement and what further refinements are necessary?

Question #24 for the Board: *Please explain why the Board lacks sufficient evidence to clarify the existing requirement of what outpatient facilities must be accredited or promulgate more stringent regulations to raise minimum standards for accreditation, emergency plans, mandatory reporting events, and so on. Are the criteria used by accreditation agencies recognized by the Board consistent, and if not, should more uniform accreditation criteria be established? What actions has the Board taken against physicians in unaccredited offices and what are the number of reports the Board has received regarding deaths or transfers to hospitals pursuant to the reporting requirement of AB 271?*

Background: The Board generally has no jurisdiction over facilities. Facilties, such as hospitals, clinics, ambulatory surgical centers, and certain other facilities, are under the purview of the Department of Health Services (DHS). The one exception to this is certain outpatient surgery settings engaging in some practices defined in law, performed outside hospitals and certified facilities. California has had an "outpatient surgery" law on the books since January 1, 1995, and it went into effect for physicians on July 1, 1996. AB 595 (Speier) was Board-sponsored legislation and was the outcome of the kind of horror stories found in our complaint files and media reports, mostly surrounding plastic and cosmetic procedures in physcian offices and the outcome of procedures performed in unlicensed abortion clinics. The Board envisioned a law more encompassing, perhaps requiring the licensure of facilities by DHS. This was opposed, however, by DHS. The final law passed was very different than what was first envisioned by the Board. In summary, the law requires that surgery performed under a certain specified level of anesthesia, if not performed in a licensed hospital or surgery center, be done in an accredited facility. The Board does not perform accreditation, but instead delegates that function to agencies it approves. Currently, there are four viable accreditation agencies. According to the Board, the law has not provided the level of patient protection, nor given the Board the ability to act proactively as was envisioned. As indicated by the Board, the way the law is currently written has left too much uncertainty about its application unless further regulations or laws are written. The most problematic portion of the law, as stated by the Board, is the determination of who must be accredited. The Board indicates that it was granted authority to promulgate regulations to further strengthen the law, but that it lacks sufficient evidence to promulgate more stringent regulations.

ISSUE #25: What steps is the Board taking to deal with the changing and emerging treatment modalities in the practice of medicine, including those associated with "alternative medicine?"

Question #25 for the Board: *Please explain what steps the Board has taken to deal with the requirements of SB 2100. What guidelines is the Board considering and when will they be adopted, and does the Board anticipate regulations to be adopted as well?*

Background: In 2000, the Legislature passed SB 2100 (Vasconcellos, Chapter 660), the Alternative Medical Practices and Treatment Act. It required the Board to address the emergence of holistic health and consider whether steps should be taken to redesign their systems to meet the healthcare needs of those seeking alternative medical treatment. It also required the Board to establish disciplinary policies and procedures by July1, 2002, to reflect emerging and innovative medical practices. To meet this mandate the Board formed an "Alternative Medicine Committee." The Board indicates that its Alternative Medicine Committee is considering some guidelines for practitioners wishing to use non-conventional methods of practice and disciplinary and investigative guidelines for cases involving alternative medicine.

DIVERSION PROGRAM ISSUES

ISSUE #26 Why was a plan not provided to the Legislature to privatize (contract out) the Board's Diversion Program? What reforms have been made to the current Diversion Program? Should the Board continue to maintain and operate its own Diversion Program?

Question #26 for the Board: *Why was a plan not provided to the JLSRC and Department to privatize the Diversion Program? What specific changes and reforms have been made to the current program to treat and monitor participants in the program, and ensure protection of the public from physicians who are impaired due to abuse of alcohol or other drugs, or due to mental or physical illness?*

Background: At the last sunset review, the Department and the JLSRC voiced concerns about the Board's Diversion Program which monitors licensees with substance abuse problems, and occasionally, mental illness. As indicated by the JLSRC, California appears to be one of only two state medical Boards that operate its own diversion program. (With a total of about 10 states having any form of officially sanctioned diversion program.) The costs of California's diversion program had been steadily increasing, up to $786,000 for FY 96/97, yet the success rate had been decreasing, down to 16% of those who participated in FY 96/97. The JLSRC found that since the inception of the program in 1980, there have been about 800 participants, with 564 (69%) successfully completing the program - which requires two or three years of counseling and an alcohol or drug free rehabilitated lifestyle. Of the 564 "successful" participants, as of December 31, 1996, 38 participants (or 6.7%) had re-entered the diversion program. The Board reported that there were about 213 active participants in its diversion program in FY 96/97, with 35 physicians successful completing the program during that fiscal year, and 21 unsuccessfully leaving the program. The Board noted that a 1991 study indicated that participants who successfully completed the program had fewer complaints (4%) than the average for all licensed physicians (7%). Participants payed $235 per month to participate in twice-weekly group counseling sessions and also payed an additional $43 for two urine tests conducted each month. The Board argued, that the benefits of the program are in providing rehabilitation to the impaired physician while protecting the public from harm, all at a cost far less than what it might otherwise take to discipline the physician for a violation.

Criticisms of the program included: (1) that it unreasonably diverts physicians from the Board's disciplinary process; (2) that it should not be operated by the Board, but instead by an entity in the private sector separated from the Board (reducing the licensees fear of disciplinary action thereby); (3) conflict of interest on the part of program staff (e.g., group counselors) who are paid $235/mo. by participants (allegedly encouraging participant retention despite violations of the conditions of program participation); and, (4) the inability of the program to actually monitor a participating physician's compliance with agreed-to practice restrictions or cessation.

Given what was the Board's projected deficit at that time, its increasing enforcement costs, the high cost to the Board to operate this program (about $800,000 out of a budget of $31 million), the relatively low number of program participants (particularly compared to the likely number of impaired physicians generally), and the "success" rates – the JLSRC and Department questioned whether the Board should continue to operate this program. The JLSRC recommended that the Board in conjunction with other boards utilizing the Diversion Program to report to the JLSRC on September 1, 1999, on a plan to privatize the Diversion Program.

In response to this request and other concerns raised by the Department and JLSRC, the Board formed a Diversion Task Force in February 1998, and undertook an extensive review of the operation of the Program. The issue of privatization of the Diversion Program was discussed and then rejected by the Committee. However, the Board indicates that a number of reforms have been made to the current Diversion Program to ensure public protection.

It is unclear whether the reforms of the Diversion Program have addressed all of the concerns raised during the last sunset review. The costs of this program continue to rise. It cost the Board $936,000 to provide this program in FY 2000/01. There were about 273 active participants in the program as of June 30, 2001, and approximately 49 successful candidates in 1999/00. (Over the past eight years there has been about 35 successful candidates per year.)

ISSUE #27: Should the Board be able to compel a competency examination for participants within the Diversion Program?

Question #27 for the Board: *Under what circumstances would the Board require a competency examination for those participating in the Diversion Program?*

Background: The Board is concerned that physicians participating in the Diversion Program may be out of practice for some time and may not be current in medical practice skill or training. The Board recommends that they be given the authority to require a competency examination to ensure that the physician can safely practice when deemed appropriate from a rehabilitation perspective.

PUBLIC INFORMATION, DISCLOSURE REQUIREMENTS AND ACCESS OVER THE INTERNET ISSUES

ISSUE #28: There have been concerns raised about the adequacy, content, quality, format and timeliness of information provided by the Board to the public.

Question #28 for the Board: *What efforts and improvements has the Board made to information it makes available to the public regarding the Board and the licensees that it regulates? What changes to the Board's disclosure requirements are anticipated or will be discussed and what other ways is the Board considering to provide more useful and meaningful information to the public?*

Background: From August to October 1999, and subsequently in January 2000, the Public Citizen's Health Research Group (HRG) surveyed 51 boards that regulate medical doctors to determine what type of information was made available to the public over the Internet. In what format is it presented? How complete and current is it? How does it compare to the disciplinary information a consumer can get by calling the board? The HRG created a grading scale to assess the adequacy of information provided over each of the web sites it reviewed. Out of a possible A to F grade, the California Medical Board received a grade of "D." The HRG also categorized web sites as either user-friendly or not. The Medical Board's web site was considered as user-friendly.

There have also been questions raised about how soon in the disciplinary process information should be made available to the public and if reportable information to the Board, such as malpractice settlements, should also be disclosed to the public. The Board indicates that it has established a

"Committee on Public Information Disclosure" to discuss the issues surrounding the information it provides to consumers, how it might be made more meaningful to consumers, and what modifications should be made to current law or policy.

ISSUE #29: Have there been any delays in providing information to the public as required by legislation over the past four years?

Question #29 for the Board: *When did the Board begin notifying physicians of the requirements to provide this information required by legislation and what methods are used by the Board to ensure physicians are properly notified of the information that must be provided pursuant to this legislation? Is this information made available to the public over the Board's website?*

Background: AB 833 (Ortiz, Chapter 754, Statutes 1997) requires doctors performing an annual gynecological examination to provide patients a published summary of a description of the symptoms and appropriate methods of diagnoses of gynecological cancers. It also required the Department of Health Services to develop a plan for the distribution of these materials. SB 1 (Burton, Chapter 11, Statutes 1997) requires a physician examining a patient's prostate to provide information about the availability of appropriate diagnostic procedures, including the prostate antigen test. SB 402 (Green, Chapter 839, Statutes 1997) requires physicians who refuse to prescribe opioid medication for patients who request treatment for chronic intractable pain, to inform the patient that other physicians specialize in the treatment of such pain with methods that include the use of opiates.

USE OF THE INTERNET BY PHYSICIANS AND PATIENTS FOR DIAGNOSIS AND TREATMENT AND OBTAINING MEDICATIONS

ISSUE #30: Does the Board still anticipate that a registration program will be needed to deal with Telemedicine practice in California?

Question #30 for the Board: *Does the Board anticipate that there may be a need for such a registration program in the future and that the federal government may take action in this area? Are there still concerns regarding this type of practice and in protecting the public from certain aspects of telemedicine practice within California?*

Background: The Federation of State Medical Boards has proposed that all states provide a registration program in-lieu of licensure to enable practitioners to practice over state lines via technology. Pursuant to SB 2098 (Kopp, Chapter 902, Statutes 1996) the Board was given authority to work with interested parties and propose legislation later regarding a registration program. The Board formed a "Telemedicine Committee" and began discussions regarding a registration program. The most outspoken opponents to a registration program was the California Medical Association. As indicated by the Board, little has changed since those discussions. There appears to be no demand for such a program and the same opposition exists.

ISSUE #31: What actions has the Board taken regarding the unlawful prescribing and dispensing of drugs over the Internet?

Question #31 for the Board: What actions has the Board taken to deal with what may be the unlawful prescribing and dispensing of drugs over the Internet. Are there other modifications to the laws that may be necessary to deal with this problem?

Background: The Board has appointed a "Teleprescribing Committee" to deal with issues involving both the prescribing and dispensing of drugs over the Internet, especially from states outside of California. The Board indicates that it must work with the Pharmacy Board, the Attorney General and appropriate federal government agencies and other states for enforcement action.